**MEMORANDUM**

**To:** **Human Rights Advocates**
**Local Human Rights Committees**

**From:** **Christina Delzingaro**
**State Human Rights Committee Chair**

**Date:** **January 10, 2011**

**Re:** **Implementation of Recent SHRC Decisions re: LHRC Structure**

At their December 10, 2010 meeting, the State Human Rights Committee (SHRC) approved changes to the model Local Human Rights Committee (LHRC) Bylaws and established a model Cooperative Agreement between LHRCs and affiliated providers. All LHRCs are to adopt the new Bylaws by June 2011, in order for the SHRC to approve them at the SHRC's July meeting. In addition, all LHRCs are to enter into Cooperative Agreements with their affiliated providers by June 2011. The new Cooperative Agreements will replace any existing Affiliation Agreements.

The SHRC has asked me to write this memo to provide the LHRCs and Human Rights Advocates with guidance on implementing these decisions regarding LHRC structure. Attached to this memo are the report from the Subcommittee to Review LHRC Structure, model Bylaws, model Cooperative Agreement, and the Subcommittee's responses to comments from the Human Rights Advocates regarding the changes. These additional documents should provide LHRC members with background and context for the changes.

**TIMEFRAME FOR IMPLEMENTATION**

The SHRC did not specify the exact date that the new Bylaws and Cooperative Agreements are required to be in place, other than "by June 2011." My guidance is that the LHRCs should use June 30, 2011 as the deadline for adopting the new Bylaws. This would also be the date that LHRCs would need to provide the SHRC with notification of any current vacancies of any Code-mandated members (see Bylaws Article III, Section 1). June 30, 2011 would also be the date that LHRCs would need to inform the SHRC of any current activities conducted under section 12 VAC 35-115-250 D 5 of the Regulations (see Bylaws Article II E). In addition, LHRCs need to enter into Cooperative Agreements with all affiliated providers by June 30, 2011. LHRCs should share this memo and the attachments with affiliated providers as soon as possible, so that they can assist in implementation of the changes.

The SHRC understands that this will require concerted effort by the LHRCs, with assistance from the Human Rights Advocates, and will be an especially tight timeframe for those LHRCs that meet quarterly. One suggestion for meeting the deadline is for the LHRC to appoint a subcommittee that would be responsible for much of the work involved and that would meet more frequently than the full LHRC.

## PURPOSE OF CHANGES

Virginia's human rights system has changed little in administrative structure and processes since the 1980's. At that time, the system was responsible for 15 state operated facilities and 40 Community Services Boards. There were few private providers. Today, this system is responsible for literally hundreds of providers and thousands of service programs. Yet, the basic structure and duties, particularly administrative duties, have not changed.

In response to the growing number of providers, new LHRCs have been created. There are currently 78 LHRCs, with over 480 members. In addition to their role in helping to facilitate provider compliance with the Regulations, and providing technical assistance to providers, the Human Rights Advocates are responsible for providing technical assistance and training support to the LHRCs. The growth in the number of providers and LHRCs greatly increases the workload of the Human Rights Advocates at a time when budget constraints have resulted in fewer resources for the Office of Human Rights.

Although the basic structure and duties of the human rights system have remained the same, the revisions to the Regulations in 2007 did place more authority with the provider for resolving complaints at the lowest level. As a result of this change, and the determined efforts of both providers and the Human Rights Advocates to resolve complaints, only 7 of the 6,164 complaints and allegations of abuse or neglect made in fiscal year 2010 were appealed to the LHRCs, and only 1 was appealed to the SHRC.

The State Human Rights Committee began reviewing the human rights system in early 2010, with the goal of identifying those changes that could best focus our limited resources, including the resources of our LHRCs, on those activities that are most impactful in assuring the rights of individuals. The changes adopted by the SHRC at their December meeting are designed to:

- Clarify that it is the role of the LHRC to provide each individual receiving services assurance that his or her rights, as defined in the Regulations, will be protected.
- Clarify that it is the role of the Human Rights Advocate to promote and monitor provider compliance with the Regulations.
- Strengthen the partnership between the LHRCs and their affiliated providers, by shifting the relationship from a "required/ compulsory" relationship to a "collaborative/advisory" relationship.

## IMPLEMENTATION GUIDANCE

### Number of Affiliates per LHRC

Earlier this year, the SHRC decided that no new LHRCs will be created. The new Bylaws state that LHRCs may not limit the number of providers that affiliate with the LHRC, and that all denials of affiliation requests must be approved by the SHRC. These two decisions mean that an LHRC may have more affiliated providers than they have in the past. In order to fulfill the purposes and duties outlined in the Regulations, an LHRC may need to increase the number of LHRC meetings per year, reduce the number

of meetings that affiliated providers are required to attend, and/or focus their efforts on those activities that are most impactful in assuring the rights of individuals. LHRCs are strongly encouraged to review and prioritize their current activities.

**LHRCs without Code-mandated Members**

The Code of Virginia mandates that LHRCs shall include members with certain characteristics, such as "consumer" and "health care provider." It is the opinion of the SHRC that an LHRC without the Code-mandated members and/or without the required number of members may not operate adequately to provide individuals receiving services with assurance that their rights will be protected. Therefore, the new Bylaws require that LHRCs notify the SHRC in the event that the LHRC has operated for 6 months without a Code-mandated member. The Office of Human Rights has developed a spreadsheet to track LHRC membership and vacancies and the length of vacancies. The Human Rights Advocates are responsible for entering information into this spreadsheet and for keeping the information current. The Human Rights Advocates will notify the SHRC of LHRC vacancies using this document.

The new Bylaws also state that in the event that an LHRC has operated for 12 months without a Code-mandated member, the SHRC will consider the LHRC for consolidation with another LHRC, in order to ensure the protection of the rights of individuals receiving services. Please note that consolidation is not an automatic action taken by the SHRC, but the review of the viability of the LHRC is. The SHRC has appointed a subcommittee to develop a process for reviewing LHRC consolidation. This process will stress the goal of ensuring access to LHRCs by individuals receiving services. One of the many considerations will be the geographical distance between the LHRC and individuals receiving services.

**Affiliation Fees**

The Regulations require that each provider name a liaison to the LHRC who will "give the LHRC suitable meeting accommodations, clerical support and equipment, and assure the availability of records and employee witnesses upon the request of the LHRC." When the LHRCs only had one affiliated provider, that affiliate provided the LHRC with in-kind clerical support and meeting space. However, as LHRCs took on additional affiliates, it became difficult to fairly distribute these responsibilities among the providers. Many LHRCs began charging affiliated providers an "affiliation fee" to cover the costs of suitable meeting accommodations, clerical support and equipment for LHRC meetings. In the new Cooperative Agreement, the SHRC has eliminated the ability of an LHRC to charge "dues" or "fees" to affiliates.

The first issue that this change presents is what should be done with any affiliation fees currently being held by LHRCs or their fiscal agents. It is the opinion of the SHRC that these fees belong to the affiliated providers and that the providers should determine what to do with them. The second issue that this change presents is how to fairly distribute the support responsibilities among affiliates and ensure that the LHRC has consistent, professional clerical support. The revised Bylaws anticipate that one provider will be designed as responsible for being custodian of meeting minutes and all other records. LHRCs are

encouraged, as part of the implementation of these changes, to call providers together to develop a provider-driven plan to address accumulated fees and the support needs of the LHRC.

Some suggestions for meeting the requirement that each provider give support to the LHRC include:

- Support responsibilities can be shared with other providers based on a schedule mutually-agreed upon by the affiliated providers and the LHRC. The Cooperative Agreement provides space for defining the support that the affiliate will provide.

- It is acceptable for just one affiliated provider to provide this support to the LHRC. While fees cannot be determined by or paid to the LHRC, a provider may delegate their support responsibility to another provider and compensate that provider for the costs of providing the support. The providers could decide which provider will take on this role, and how the other affiliates will compensate that provider.

- Providers could decide that one provider is primarily responsible for the clerical support of the LHRC, but that each affiliate is responsible for support to the LHRC for the issues that pertain to that provider. For example, Affiliate A could provide meeting space and clerical support for routine meetings. However, if there is an appeal involving Affiliate B, Affiliate B is responsible for providing the clerical support, making sufficient copies of materials, and providing adequate meeting space to accommodate that hearing.

Finally, it should be noted that the provider giving support to the LHRC is not a member of the LHRC, nor does this provider have a greater standing with the LHRC than other providers. The LHRC should take care to ensure that there is not a perception that the provider giving support is in any different relationship with the LHRC than other affiliated providers.

**Inform SHRC of Activities under Section 12 VAC 35-115-250 D 5**

Under this section of the Regulations, LHRCs have the ability to review any existing or proposed policies, procedures or practices that could jeopardize the rights of individuals. The new Bylaws require that the LHRC inform the SHRC of any reviews under this section of the Regulations, in order that the SHRC may provide additional information, comment and guidance in conducting the review.

LHRCs are strongly encouraged to limit these activities to those which are most likely to assure the protection of individuals. It is suggested that if the LHRC has a concern with a particular provider or practice, that it limit its review to just that provider or to the element of the practice that is of most concern (i.e., if individuals have complained about Provider A's policy regarding community outings and the LHRC has concerns about the Provider's response to those complaints, the LHRC should review Provider A's policies, not request that all affiliates submit their policies).

LHRCs are also encouraged to remember that their role is to assure the protection of individual rights, not to monitor compliance with the Regulations, or to perform quality assurance or risk management

functions. Therefore, LHRCs should not be routinely reviewing medication error reports, falls reports or behavioral treatment plans that do not include the use of restraint or time out.

The SHRC does not have to be informed of activities under Section 12 VAC 35-115-250 D 5 prior to the LHRC engaging in them. The purpose of informing the SHRC is for the SHRC to be able to provide information and guidance to the LHRC.

In order to implement this new process, each LHRC should review its current activities and classify them according to the purposes and duties outlined in the Regulations:

- Permit affiliations of providers and enter into cooperative agreements
- Receive complaints of alleged rights violations and hold necessary hearings
- Conduct investigations as requested by the SHRC
- Receive, review and make recommendations to the SHRC concerning applications for variances to the Regulations
- Receive, review and comment on all behavioral treatment plans involving the use of restraint or time out
- Receive, review and comment on seclusion, restraint or time out policies
- Review individual's consent and authorization objections, contested authorized representative appointments, and contested capacity evaluations at the request of an individual or their representative
- Review "Next Friend' Authorized Representative designations
- Identify training needs of LHRC members
- Other activities, including reviewing policies, procedures, and practices that could jeopardize the rights of individuals

The LHRC should review its current activities that fall into the last category and determine if the LHRC wishes to continue these activities. The LHRC should compile a list of its activities in this category that it will be continuing, the intent of the review, the providers who fall under the review, and any other information to assist the SHRC in understanding the activity. This list should be forwarded to the SHRC by June 30, 2011. As the LHRC conducts reviews in the future, they LHRC should provide this information to the SHRC immediately after the LHRC meeting at which the activity is initiated.

**LHRC Review of Behavioral Plans**

The Regulations require that LHRCs receive, review and comment on all behavioral treatment plans involving the use of restraint or time out and seclusion. LHRCs should not be routinely reviewing other behavioral treatment plans.

Intermediate Care Facilities for the Mentally Retarded (ICFMRs) are required by Medicaid to have a committee (the "specially constituted committee") review a range of behavior plans and programs, beyond just those plans involving the use of restraint or time out. Some ICFMRs have been using the LHRC for this function. It is recommended that the LHRC not be the "specially constituted committee." The LHRC is a citizen body, open to the public, designed to assure rights under the Regulations. The

"specially constituted committee" is an internal quality assurance body that consists of citizen members, designed to ensure appropriate treatment of individuals. Those providers that use an LHRC as a quality assurance or risk management committee should also consider separating these activities from the LHRC and creating a separate committee.

If the provider wishes to avoid having to recruit, support and maintain two separate volunteer groups, the provider could have the same volunteers serving on both committees. The committee that fulfills the Medicaid requirement or quality assurance/risk management function could meet immediately before or after the LHRC, but it would be a separate committee meeting.

The Human Rights Advocate is responsible for reviewing restrictive treatment plans involving rights such as use of the telephone, visitors and access to community outings prior to their implementation. If the Advocate would like to educate the LHRC about these types of plans, the Advocate can do so, but it is not the LHRC's role to review the actual plans. If the LHRC has concerns about a provider's use of these types of restrictions (based on information the LHRC receives from the Advocate), the LHRC may request additional information from the provider (under Section 12 VAC 35-115-250 D 5).

**Definition of Health Care Provider**

The Code of Virginia requires that each LHRC have at least one health care provider. In 2005, the SHRC issued a memorandum outlining who would be considered as health care providers for the purposes of LHRC membership. A copy of that memorandum is attached. The SHRC realizes that many LHRCs are having difficulty recruiting to fill this position, and it has appointed a subcommittee to review the current definition. LHRCs will be informed if any changes to the definition are recommended by the subcommittee. In the meantime, LHRCs are to use the definition in the 2005 memorandum.

**LHRC Officers – Secretary**

The new Bylaws specify that each LHRC shall have a Secretary. This Officer is responsible for ensuring minutes and notices are posted as required, and for ensuring that the LHRC provider liaison designated as being custodian of meeting minutes and all other records of the LHRC is maintaining records appropriately. The Secretary is responsible for coordinating the support provided to the LHRCs by the affiliates. The Secretary is a member of the LHRC. This position is separate from the clerical support provided to the LHRCs by the affiliates. LHRCs that currently do not have a Secretary need to elect a member to fill this position by June 30, 2011.

**Provider Attendance at LHRC Meetings**

The new Cooperative Agreement states that providers must attend LHRC meetings according to a schedule that will be provided by the LHRC, but no less often than annually. The LHRC can require a provider to attend more frequently. However, in keeping with a more collaborative approach, it is preferable that the requirement to attend more frequently be limited to those providers for whom the LHRC and/or the Advocate have particular concerns. This will be particularly important as LHRCs take on more affiliates than they have in the past.

While the SHRC advises that the requirements for mandatory attendance be reduced, LHRCs could encourage more frequent provider attendance by making LHRC meetings more meaningful, useful and productive (as opposed to compulsory) for the providers. One suggestion would be for the LHRC meeting to include a training/educational component which would benefit both LHRC members and the providers.

The LHRC can also engage the providers other than during the LHRC meeting. Providers could be encouraged to read LHRC minutes posted on the DBHDS website, for example.

Providers can also be more involved in and accountable to the human rights system through their relationship with their Human Rights Advocate. Advocates are encouraged to engage providers at times other than LHRC meetings through email or phone if face-to-face contact is not feasible, and to provide training to LHRC members and providers at LHRC meetings to encourage provider's elective attendance. Advocates can also send out periodic update emails about human rights trends to providers. The goal is to strengthen the relationship between Advocate and provider, consistent with the vision articulated during the SHRC/OHR April meeting. ("We will know when the human rights system is successful when providers and individuals seek training and consultation regarding the Regulations.")

**Provider Compliance with the Regulations**

The new Cooperative Agreement outlines a collaborative approach to the relationship between the LHRC and its affiliated providers. This approach does not reduce the provider's obligation to comply with the Regulations; it clarifies the role of the LHRC.

It is the Human Rights Advocate's responsibility to help facilitate providers' compliance with the Regulations. This includes cooperating with the LHRC, as well as timely reporting of complaints and allegations of abuse/neglect. Those providers who are not compliant risk a Licensure citation and sanctions invoked by the Commissioner.

The SHRC recognizes that implementing these changes may present challenges for some LHRCs. If you have questions or require additional guidance, please contact me at cdelzingaro@verizon.net. Thank you for all of your work to assure the rights of individuals receiving services.